

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012941
STATE FILE NUMBER

Health,
Welfare
Public
Service

FILED MAY 11 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 445

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Dade | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Greenfield 0290 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | Length of stay in 1b 1 week | d. STREET ADDRESS (If outside, give location) 215 Lilly St Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Otto Edward Gillman | | | 4. DATE OF DEATH Month Day Year May 2, 1959 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 6, 1894 |
| 9. AGE (In years last birthday) 64 | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and state or country) Dade County, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13a. FATHER'S NAME John Henry Gillman | |
| 13b. MOTHER'S MAIDEN NAME Catherine Jones | | 14. NAME OF HUSBAND OR WIFE Erma Gillman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 497-12-8358 | |
| 17. INFORMANT Mrs. Erma Gillman; Greenfield, Mo. | | Address 215 Lilly St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction. | | | INTERVAL BETWEEN ONSET AND DEATH P-10 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease | | | 2 years. |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Rt. Lower Lobe pneumonia | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from 4-24-59 , to 5-2-59 and last saw ^{him} alive on 5-1-59 (2 hours before death) Death occurred at 12:35 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Harold H. Lurie, M.D. | | 22b. ADDRESS 609 Cherry Springfield, Mo. | 22c. DATE SIGNED 5-6-59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE May 4, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Lockwood Cem. |
| 23d. LOCATION (City, town, or county) Lockwood, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR J. C. Canada, Greenfield, Mo. | | 25. DATE RECD. BY LOCAL REG. 5-7-59 | 26. REGISTRAR'S SIGNATURE Effie E. Melton |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JUL 22 1959

MAY 14 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *J. C. Canada*

Licensed Embalmer No. *4196*
P. O. Address *Greenfield, No*

Note--The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.